



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: CAMPBELLWILSON ON BEHALF OF TEXAS INSTITUTE FOR SURGERY 15770 NORTH DALLAS PARKWAY STE 500 DALLAS TX 75248	MFDR Tracking #:	M4-09-B150-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: TRAVELERS PROPERTY CASUALTY CO REP. BOX #: 05	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "On behalf of Texas Institute of Surgery, we are submitting this complaint regarding denial of correct payment on the above-referenced account. The carrier, Travelers, has denied reimbursement at the contracted state fee guideline for this Workers' Compensation Claim. We have appealed to the Workers' Compensation carrier, requesting reconsideration of the denial and citing the hospital fee guideline published by the Department of Workers Compensation (DWC) which states that *the reimbursement calculation shall be the Medicare facility specific amount multiplied by 200%*. We respectfully submit that [injured worker's] claim meets the reimbursement criteria and consequently, should be paid at 200% of the Medicare facility specific rate and subsequent procedures at 50% of the reimbursement rate..."

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill
3. EOBs
4. Medical Reports
5. Total Amount Sought \$942.22

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...The Provider's Request for Medical Dispute Resolution involves reimbursement for outpatient hospital services. The Provider submitted billing for the facility fee for a rotator cuff repair in the amount of \$24,232.76. The Carrier reviewed the submitted billing and reimbursed the Provider \$8,433.47 in accordance with the adopted Hospital Outpatient Fee Guideline. The Provider subsequently filed this Request for Medical Dispute Resolution, alleging the Carrier had reimbursed less than the Hospital Outpatient Fee Guideline Maximum Allowable Reimbursement. The Carrier has reviewed the reimbursement previously issued and maintains that reimbursement was issued in accordance with the Hospital Outpatient Fee Guideline Maximum Allowable Reimbursement. The Carrier contends the Provider is not entitled to additional reimbursement..."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS				
Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
03/02/2009	CPT Code 29826-RT	APC calculation for CPT Code 29826-RT is \$3,215.22(APC) +\$0.00(Outlier Amount) = \$3,215.22(OPPS) x 200% = 6,430.44 (MAR) - \$4,180.38(Total paid by Respondent) = \$2,250.06	\$2,237.96	\$2,237.96
03/02/2009	CPT Code 23412-RT-59	APC calculation for CPT Code 23412-RT-59 at the multiple procedure 50% rate is \$1,481.46 (APC) = \$0.00 (outlier Amount) = \$1,481.46 x 200% = \$2,962.92 - \$1,933.62 = \$1,029.30	\$1,023.73	\$1,023.73
03/02/2009	Revenue Codes 278, 370, 420	Requestor listed these revenue codes with a negative balance totaling \$2,319.47	\$0.00	(\$2,319.47)
Total Due:				\$942.22
PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION				
<p>Texas Labor Code Section 413.011(a-d), titled <i>Reimbursement Policies and Guidelines</i>, and Division Rule §134.403, titled Hospital Facility Fee Guideline – Outpatient, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.</p> <p>This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).</p> <ol style="list-style-type: none"> The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes: Explanation of benefits with the listed date of audit 04/03/2009: <ul style="list-style-type: none"> FEES, W1 – Workers Compensation State F/S adj. reimbursement based on max allowable fee for this proc. Based on medical F/S, or if on is not specified, UCR for this Zip Code area. Explanation of benefits with the listed date of audit 04/24/2009: <ul style="list-style-type: none"> DUPP, 18 – Duplicate claim/service. These services have already been considered for reimbursement. Rule 134.403 (e) states in pertinent part, “Regardless of billed amount, reimbursement shall be: <ol style="list-style-type: none"> the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;” Pursuant to Rule §134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the <i>Federal Register</i>. The following minimal modifications shall be applied. <ol style="list-style-type: none"> The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: <ol style="list-style-type: none"> 200 percent; unless a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by 				

Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:
 - (1) No contract exists;
 - (2) MAR can be established for these services; and
 - (3) Separate reimbursement for implantables was *NOT* requested by the requestor.
6. Pursuant to Rule §134.403 (g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.
 - (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."
7. Upon review of the documentation submitted by the requestor and the respondent it has been determined that in accordance with §134.403(f) the respondent has not correctly reimbursed the requestor for CPT Codes 29826-RT and 23412-RT-59. These two codes are considered by Medicare to be Status T codes. Status T codes are outpatient significant procedures and subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. The APC payment for CPT Code 29826-RT is \$3,215.22, for CPT Code 23412-RT-59 is \$1,481.46 for a total APC rate of \$4,696.68; this amount multiplied by 200% equals a total allowable of \$9,393.36. The Respondent reimbursed the Requestor \$6,114.00 for these two codes leaving a balance of \$3,279.92.
8. The Requestor has listed Revenue Code 420 on the Table of Disputed Services. Review of the UB-04 shows services under this revenue code, are physical therapy evaluation and physical therapy rendered to the claimant during this outpatient stay. CPT Code 97001 and CPT Code 97110 are considered by Medicare to be Status A codes. Status A codes are paid under a fee schedule. In accordance with Division Rule 134.403(h), for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2), and for which Medicare reimburses using other Medicare fee schedules reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided. Consequently, payment for these two codes is priced according to Division Rule 134.203. The Respondent paid the Requestor, \$105.05 for CPT Code 97001 and \$42.22 for CPT Code 97110 for a total of \$140.47. The allowable amount in accordance with Division Rule 134.203 is \$105.48 for CPT Code 97001 and \$42.22 for CPT Code 97110 for a total of \$147.27; however the Requestor has listed a negative balance of <\$147.47> for these two codes; as such these codes are not considered in dispute.
9. The Requestor has listed Revenue Code 278 on the Table of Disputed Services. Review of the UB-04 shows services under this revenue code to be Supply/Implants. The Requestor has only listed HCPCS Code C1713 on one line and did not list a CPT/HCPCS code. According to Medicare the line item without a CPT/HCPCS code has a line item error definition of 865. Definition 865 denotes a Revenue Code 272, 275, 276, or 278, with no CPT/HCPCS code indicates a possible pass-through device. HCPCS Code C1713 is considered to be a Status N code. Status N codes are services or procedure included in the APC rate, but not paid separately as this is a packaged item. The allowable amount in accordance with Division Rule §134.403 is \$0.00. The Respondent reimbursed the Requestor a total of \$2,156.00; however the Requestor has listed a negative balance of <\$2,156.00> for these two codes; as such, these codes are not considered in dispute.
10. The Requestor has listed Revenue Code 370 on the Table of Disputed Services. Review of the UB-04 shows services under this revenue code to be anesthesia. The APC rate for Revenue Code 370/Anesthesia is \$0.00; the Respondent reimbursed the Requestor \$16.20; however the Requestor has listed a negative balance of <\$16.20> for this Revenue Code; as such, this code is not considered in dispute.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is \$942.22.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of \$942.22 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Medical Fee Dispute Resolution Officer

April 26, 2010

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.